**DEPARTMENT OF SOCIAL AND HEALTH SERVICES**
**MEDICAL ASSISTANCE ADMINISTRATION**
**Olympia, Washington**

**To:** Prosthetic Providers
Orthotic Providers
Managed Care Plans
Regional Administrators
CSO Administrators

**Memorandum No.:** 02-82 MAA
**Issued:** October 11, 2002

**For More Information, call:**
1-800-562-6188

**From:** Douglas Porter, Assistant Secretary
Medical Assistance Administration

**Subject:** **Updates to the Prosthetic and Orthotic Devices Billing Instructions**

The purpose of this memorandum is to provide providers with updates to billing instructions due to revisions to WAC 388-543-1000 and 2200. Please note changes in billing policy/procedures and definitions of terms used in MAA's Prosthetic and Orthotic Devices Billing Instructions.

# What are the updates?

## Billing Policy/Procedure Changes

**Effective for dates of service on and after November 1, 2002**, MAA will require:

- Valid ICD-9-CM codes on all billings. MAA will no longer allow the use of unspecified diagnosis codes such as V58.9; and

- Written requests for prior authorization must be submitted to MAA on a HCFA-1500 claim form with the date of service left blank and a copy of the prescription attached.

## Definition Change

- The definition for "Fee-for-Service" has been altered and a definition for "Limitation Extension" has been added.

Attached are replacement pages v-viii, E.1/E.2, and I.3/I.4 for MAA's Prosthetic and Orthotic Devices Billing Instructions, dated September 2001, reflecting the above updates.

To obtain MAA's Billing Instructions and/or Numbered Memorandums electronically, go to: http://maa.dshs.wa.gov (click on the Provider Publications/Fee Schedules link).

# Definitions

**This section defines terms and acronyms used in these billing instructions.**

**Artificial limb** – See prosthetic device. [WAC 388-543-1000]

**By Report (BR) –** A method of reimbursement for covered items, procedures, and services for which the department has no set maximum allowable fees. [WAC 388-543-1000]

**Client -** An applicant for, or recipient of, DSHS medical care program.

**Code of Federal Regulations (CFR) -** A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

**Community Services Office (CSO)** - An office of the department that administers social and health services at the community level. [WAC 388-500-0005]

**Core Provider Agreement** - The basic contract that MAA holds with providers serving MAA clients. The provider agreement outlines and defines terms of participation in Medical Assistance.

**Date of Delivery –** The date the client actually took physical possession of an item or equipment. [WAC 388-543-1000]

**Department** - The state Department of Social and Health Services [DSHS]. [WAC 388-500-0005]

**Expedited Prior Authorization** – The process for obtaining authorization for selected durable medical equipment, and related supplies, prosthetics, orthotics, medical supplies and related services, in which providers use a set of numeric codes to indicate to MAA which acceptable indications/conditions/MAA-defined criteria are applicable to a particular request for DME authorization. [WAC 388-543-1000]

**Explanation of Benefits (EOB)** - A coded message on the Medical Assistance Remittance Advice and Status Report (RA) that gives detailed information about the claim associated with that report.

**Explanation of Medicare Benefits (EOMB) –** A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

**Fee-for-Service** – The general payment method MAA uses to reimburse for covered medical services provided to clients, except those services covered under MAA's prepaid managed care programs. [WAC 388-543-1000]

**Health Care Financing Administration Common Procedure Coding System (HCPCS)** – A coding system established by the Health Care Financing Administration to define services and procedures. [WAC 388-543-1000]

**Internal Control Number (ICN) -** A 17-digit number that appears on your Remittance Advice and Status Report (RA) by the client's name. Each claim is assigned an ICN when it is received by MAA. The number identifies that claim throughout the claim's history.

**Limitation Extension** – A process for requesting and approving covered services and reimbursement that exceeds a coverage limitation (quantity, frequency, or duration) set in WAC, billing instructions, or numbered memoranda. Limitation extensions require prior authorization. [WAC 388-543-1000]

**Managed Care** - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services.
[WAC 388-538-050]

**Maximum Allowable** - The maximum dollar amount for which a provider may be reimbursed by MAA for specific services, supplies, or equipment.

**Medicaid -** The state and federally funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

**Medical Assistance Administration (MAA) -** The administration within DSHS authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI Children's Health Insurance Program (CHIP), and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

**Medical Identification card(s)** – Medical Identification cards are the forms DSHS uses to identify clients of medical programs. These cards are good only for the dates printed on them. Clients will receive a Medical Identification card in the mail each month they are eligible. These cards are also known as DSHS Medical ID cards and were formerly called medical coupons or MAID cards.

**Medical Management, Division of (DMM)** - A division within the Medical Assistance Administration responsible for the administration of the quality improvement and assurance programs, utilization review and management, and prior authorization for fee-for-service program.

**Medically Necessary** - A term for describing [a] requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

**Medicare** - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. [WAC 388-500-0005]

**Orthotic Device or Orthotic –** A corrective or supportive device that:

- Prevents or corrects physical deformity or malfunction; or
- Supports a weak or deformed portion of the body. [WAC 388-543-1000]

**Patient Identification Code (PIC)** - An alphanumeric code that is assigned to each MAA client consisting of:

- First and middle initials (a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

**Prior Authorization** – A process by which clients or providers must request and receive MAA approval for certain medical equipment and related supplies, prosthetics, orthotics, medical supplies and related services, based on medical necessity, before the services are provided to clients, as a precondition for provider reimbursement. Expedited prior authorization and limitation extension are types of prior authorization. Also see WAC 388-501-0165. [WAC 388-543-1000]

**Program Support, Division of (DPS)** – The division within MAA responsible for providing administrative services for the following:

- Claims Processing;
- Family Planning Services;
- Administrative Match Services to Schools and Health Departments;
- Managed Care Contracts; and
- Provider Enrollment/Relations

**Prosthetic device or prosthetic** – A replacement, corrective, or supportive device prescribed by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice as defined by state law, to:

- Artificially replace a missing portion of the body;
- Prevent or correct physical deformity or malfunction; or
- Support a weak or deformed portion of the body. [WAC 388-543-1000]

**Provider or Provider of Service -** An institution, agency, or person:

- Who has a signed agreement [Core Provider] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. [WAC 388-500-0005]

**Remittance Advice and Status Report (Referred to as "RAs")-** A report produced by the Medicaid Management Information System (MMIS) that provides detailed information concerning submitted claims and other financial transactions.

**Resource Based Relative Value Scale (RBRVS)** – A scale that measures the relative value of a medical service or intervention, based on amount of physician resources involved. [WAC 388-543-1000]

**Revised Code Of Washington (RCW) -** Washington State laws.

**Third Party** - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client.

**Usual and Customary Charge –** The amount the provider typically charges to 50% or more of his or her non-Medicaid clients, including clients with other third-party coverage. [WAC 388-543-1000]

**Washington Administrative Code (WAC) -** Codified rules of the State of Washington.

# Authorization

## What is prior authorization?

Prior authorization (PA) is MAA's approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement. **Expedited prior authorization (EPA) and limitation extensions (LE) are forms of prior authorization.**

## Is Prior Authorization required? [Refer to WAC 388-543-1600]

**Yes!** The Medical Assistance Administration (MAA) requires prior authorization for certain purchases and repairs of medically necessary P&O devices and related supplies and services. Please refer to the PA column of the *Fee Schedule* (Section H) for items that require prior authorization.

MAA bases its determination about which P&O devices and related supplies and services require PA or EPA on utilization criteria. MAA considers all of the following when establishing utilization criteria:

- High cost;
- Potential for utilization abuse;
- Narrow therapeutic indication; and
- Safety.

### How do I request prior authorization?

Providers must submit the request in writing to the Quality Utilization Section or call the authorization toll-free number at 1-800-292-8064. (See *Important Contacts* section.)

## General Policies for Prior Authorization

**[Refer to WAC 388-543-1800]**

- For PA requests, MAA requires the prescribing provider to furnish patient-specific justification for base equipment and each requested line item accessory or modification identified as a separate charge. MAA does not accept general standards of care or industry standards for generalized equipment as justification.

- When MAA receives an initial request for PA, the prescription(s) for those items or services cannot be older than three months from the date MAA receives the request.

- MAA requires certain information from providers to prior authorize the purchase of equipment. This information includes, but is not limited to, the following:

  ✓ A detailed description of the item; and
  ✓ Any modifications required, including the product or accessory number as shown in the manufacturer's catalog.

- MAA prior authorizes By Report (BR) items that require PA and are listed in the *Fee Schedule* (section H) only if medical necessity is established and the provider furnishes all of the following information to MAA:

  ✓ A detailed description of the item or service to be provided;
  ✓ The cost or charge for the item;
  ✓ A copy of the manufacturer's invoice, price-list or catalog with the product description for the item being provided; and
  ✓ A detailed explanation of how the requested item differs from an already existing code description.

- MAA does not reimburse for purchase or repair of medical equipment that duplicates equipment the client already owns. If the provider makes such a request, MAA requires the provider to submit a PA request and explain the following:

  ✓ Why the existing equipment no longer meets the client's medical needs; or
  ✓ Why the existing equipment could not be repaired or modified to meet those medical needs.

- A provider may resubmit a request for PA for an item or service that MAA has denied. MAA requires the provider to include new documentation that is relevant to the request.

- MAA prior authorizes extensive maintenance that the manufacturer recommends be performed by an authorized dealer. MAA requires the client to take responsibility for routine maintenance of a prosthetic or orthotic. If the client does not have the physical or mental ability to perform the task, MAA requires the client's caregiver to be responsible. **[WAC 388-543-2600 (4)]**

☞ **Note:** Written requests for prior authorization must be submitted to MAA on a HCFA-1500 claim form with the date of service left blank and a copy of the prescription attached.

**10**. **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

**11**. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and MAA pays as payor of last resort.

**11a. Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

**11b. Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

**11c. Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

**11d. Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. If **11d.** is left blank, the claim may be processed and denied in error.

**17. Name of Referring Physician or Other Source**: When applicable, enter the referring physician or Primary Care Case Manager name.

**17a. I.D. Number of Referring Physician**: When applicable, 1) enter the seven-digit, MAA-assigned identification number of the provider who *referred or ordered* the medical service; OR 2) when the Primary Care Case Manager (PCCM) referred the service, enter his/her seven-digit identification number here. If the client is enrolled in a PCCM plan and the PCCM referral number is not in this field when you bill MAA, the claim will be denied.

**19. Reserved For Local Use**: When applicable, enter indicator **B** to indicate *Baby on Parent's PIC*. Please specify *twin A or B, triplet A, B, or C* here.

**21. Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4. A valid ICD-9-CM code will be required. MAA no longer allows the use of an unspecified/ dummy diagnosis code such as V58.9.

**22.** **Medicaid Resubmission**: When applicable. If the billing is resubmitted beyond the 365-day billing time limit, you must enter the ICN to verify that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.)

**23.** **Prior Authorization/EPA Number**: When applicable. If the service or equipment you are billing for requires authorization, enter the nine-digit number assigned to you. Use only one authorization number per claim.

**24.** **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

**MAA does not accept "continued" claim forms. Each claim form must be totaled separately.**

**24A.** **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., November 4, 2001 = 110402). **Do not use slashes, dashes, or hyphens to separate month, day, year.**

**24B.** **Place of Service**: Required. These are the only appropriate code(s) for this billing instruction:

| Code Number | To Be Used For |
|---|---|
| 4 | Client's residence |
| 7 | Nursing facility (formerly ICF) |
| 8 | Nursing facility (formerly SNF) |
| 9 | Other |

**24C.** **Type of Service**: Required. Enter a **9**.

**24D.** **Procedures, Services or Supplies HCPCS**: Required. Enter the appropriate Centers for Medicare and Medicaid (CMS) (formerly known as HCFA) Common Procedure Coding System (HCPCS) or state-unique procedure code for the services being billed. **MODIFIER:** When appropriate enter a modifier.

**24E.** **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM. A valid ICD-9-CM code is required. MAA no longer allows the use of an unspecified/dummy diagnosis code such as V58.9.